Ep #42: Exploring the Many Paths to Parenthood: A Fertility Expert's Perspective

Full Episode Transcript

With Your Host

Devon Clement

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Welcome to *Parenthood Prep*, the only show that helps sleep-deprived parents and overwhelmed parents-to-be successfully navigate those all-important early years with their baby, toddler, and child. If you are ready to provide the best care for your newborn, manage those toddler tantrums and grow with your child, you're in the right place. Now here's your host, baby and parenting expert, Devon Clement.

Devon Clement: Hello and welcome to the Parenthood Prep Podcast. Today we have a guest that I'm really excited to talk to. As per usual, we had an amazing call leading up to the podcast where we talked about everything and I hope we can recreate that on the recording and hopefully bring in some new gems. So why don't you introduce yourself, Justine?

Justine Witzke: Great, thank you so much for having me. I'm excited to be here. And yes, I wish we had recorded that first call. It would have accomplished all the goals.

So I'm Justine Witzke, and I am the founder and CEO of Lineage Fertility, which is a boutique human-centered sperm bank and fertility consultancy here in midtown Manhattan.

And I've worked in reproductive medicine for my entire career, almost 20 years. Most of that time was at a really well-regarded, large IVF program here in New York. And I did a master's in public health and a PhD in translational research and have somehow found my niche in this fertility space. So I'm excited to talk about it.

Devon: That's great. Something that took me a while to realize because I've been so ingrained in the birth and baby world for so long is that this is not something that a lot of people know about who haven't been through it.

People think you try to have a baby, you have sex, you get pregnant, maybe you have to track your cycle for a little bit, but then they hear about IVF and things like that and they don't know what that means.

Friends of mine are going through the process now. They're a gay couple and they're using donors and surrogates. And a lot of our other friends are like,

what? How does that work? And I'm just like, oh yeah, you do this and you do this and this and that. So I think in my mind it's common knowledge, but it's not really.

Justine: So to me it is too, of course, because this is the language I've been speaking for so long, but there are so many possible paths to becoming a parent. And if someone wants to be a parent, there's a way to do it. It may not look exactly like what they had imagined. It may be much more time-consuming or resource-intensive or uncomfortable, a lot more uncomfortable than they anticipated it might be, but there's a way to do it.

And when we think of who needs fertility treatment, it could be almost anyone, right? Somebody who's becoming a single parent by choice often will use fertility services to build their family. Same-sex couples, queer, lesbian couples, transgender individuals with their partners may pursue family building through reproductive technologies. But also heterosexual couples who are having trouble conceiving or who have, are both carriers for the same genetic disorder and don't want to pass that on or the list goes on and on.

Devon: Yea, that's a big one.

Justine: People who might pursue family building through assisted reproductive technologies. And there are a lot of different paths even within what this specialty is. Some people think of fertility treatment only as IVF. And IVF is probably the most common, the most effective, the most popular.

Devon: And just to give a quick like little two sentences, what is IVF? Yeah. People don't know.

Justine: I know. Exactly. That's probably the most popular thing, but what it really involves is 2 weeks of injectable medications to stimulate the body to produce more mature eggs than it normally would at one time. Typically, the female body is going to produce enough hormones to mature one egg at a time. That's the egg we think of as ovulating.

And with these medications, hopefully we can have five or 10 or maybe 20 eggs mature at the same time, and be collected through an egg retrieval, which is a

simple surgical procedure. We access the ovaries transvaginally, so there's a little puncture wound of the vaginal wall. They use suction, they collect the eggs. Now the eggs are in the embryology lab and they're going to take sperm that's either from the partner provided that day or maybe it's frozen sperm from a partner or from a sperm donor, whatever the plan is for the patient and fertilize those eggs. There are then a couple ways that can be done.

Embryos are made. Maybe the embryo is transferred back to the uterus three days later, five days later. Maybe it's frozen and transferred a month later or 10 years later. So with all of these things, there are many, many right answers and many, many possible paths to getting to the baby.

Devon: The egg process is something I'm familiar with because I have done egg freezing. So I have frozen eggs and it's the same process, right? If you're doing eggs for egg freezing or you're doing it for immediately doing IVF with your partner or by yourself. I have a girlfriend who used a sperm donor and had to do IVF for that process. And then she carried, you know, like I said, my friends who are a gay couple are using a surrogate. So they created the embryo from the donor egg and their sperm, and then they transferred that to a surrogate. So there's different phases of the process.

Justine: So the egg donor and you and me, when we froze our eggs, and the person who's trying to conceive from IVF this month are all doing essentially that same process. It's just sort of where it is truncated? Are we collecting the eggs and freezing them an hour later? Are we collecting the eggs and fertilizing them and transferring a fresh embryo? Or maybe we're collecting eggs, fertilizing them, freezing those embryos and transferring embryos later on.

Maybe that embryo transfer happens to a surrogate, right? Like in the case of a gay male couple who's working with an egg donor and a gestational surrogate or maybe that embryo transfer later on is happening to the egg provider, right? The same person who provided the eggs is going to also come to carry the pregnancy.

Devon: And you could get a couple of embryos, transfer one, freeze the rest, save them for subsequent pregnancies.

Justine: For sure. That's sort of the hope.

Devon: That you only have to go through the process once and get multiple. I know a family member of mine had issues staying pregnant. So she used a surrogate and had her twins. And then she's like, a couple years later, she's like, you know, we have one embryo left. We might as well just give it a shot.

And they found another surrogate and now she's got a little one. So, you know, you never know. She's like, if it takes, great. If not, we have the twins. You know, either way.

Right. What I'm hearing more and more about that I think is so fascinating is donor embryos, that people who have left over embryos after they're finished building their family, they donate to other families. I have a girlfriend who has two kids from two separate donor embryo families.

Justine: Yeah, I think it's gaining quite a bit of popularity. There have been embryo donation programs that have existed for decades at this point, but with all of fertility treatment, there are a lot of layers of what people feel comfortable with physically, ethically, etc. Embryo donation adds maybe some extra layers for some people because those donated embryos, if they have children from the same batch of embryos or from that same original embryo collection, are full genetic siblings that are members of another family.

And in this day and age, it would be lovely, and I hope that in many of these cases, these kids are going to get to know each other, right? Maybe they're not going to be socialized as siblings, but hopefully they will get to know that they exist and that there's transparency and openness that this embryo donation happened or that someone was born from embryo donation.

I think that's such a useful and helpful part of working in third party reproduction is that over time, the transparency and the willingness for openness about third party reproduction has really, really expanded. When I first started working in this field, 17 years ago, you know, people didn't want to be seen walking in the building, let alone tell someone they used an egg donor or sperm donor or donated embryo. And now people are seeing their friends in the waiting room and they're sending their sister and they're finding the donor siblings on social

media or on the donor sibling registry. And I think it's such a nice evolution of the field to see.

Devon: Very nice. Very nice. And I think it's really important because if you're involved in any of the literature or the social media about these donor-conceived kids growing up, it's similar to an adoption. You're not being raised by your genetic family, and you want to make those connections. And God forbid it happens more often than you'd think.

These kids that are from the same donor are ending up in relationships with each other, which sounds like, oh, that just happens in the movies, but apparently it happens more than you'd think.

Justine: There are true consequentity risks, right? And if the same egg donor, for example, is used by five families within the same year in the same geographic location, like could those kids all be of similar ages? For sure, right? An embryo donation that the embryo was from 12 years ago, you know, it's a bit of a different scenario. But at a baseline, there's at least sort of this hope that people who are conceived from donor gametes will be able to have a better understanding of their own family medical history.

That's sort of bare minimum, That would be what the hope is. And then the social piece of it, I think, is a newer evolution of that thinking.

Devon: Yeah. I mean, I read a story of a woman who had donated eggs years ago. I guess she was in college or whatever. And then later on was diagnosed with some kind of something that did have a genetic connection. And she's like, I'm trying to find my egg recipients so that I can tell them that I have this thing and that they need to get screened or whatever.

So, and I guess for whatever reason, the legalities or whatever, she wasn't able to find them through those channels. So she was literally like putting the word out on social media. Like if you received an egg from blah, blah clinic and blah, blah year, then let me know. It could be my egg.

Justine: That's a lot of diligence on her part. Yeah. You know, most egg and sperm donors are told and asked, oh, you know, if something changes in your

own medical history or in your family medical history, call us up and let us know. And then the onus is sort of on the clinic that did the treatment to reach out to those families who did have a baby via that egg or sperm donor and relay that information, give them access to genetic counselors or whatever other appropriate testing there would be. One thing that we're doing in our program here at Alineage Fertility, we're recruiting sperm donors.

So we're trying to build a boutique donor bank where we will meet and screen the donors and we will meet the recipient and the recipient will get to ask us what we think of them, right? And we'll be able to say, based on what you're telling us, I think you should look at these two profiles rather than scroll through what feels like the whole internet searching for a donor.

Devon: Sure. I know my girlfriend struggled with that tremendously. For sure. So many choices. I guess back in the day, they used to give you basically a big catalog.

Justine: Right. There used to be binders. Now it's a database. And there are so many choices with a caveat that there's really limited diversity in sperm donor availability. So hopefully by recruiting in New York, we can try to address that part of it too.

But what we're also seeing develop with sperm donation and matching is what I've kind of referred to as facilitated known donation, where not necessarily your friend, but someone who you get matched with and become friends with serves as a sperm donor. So that's sort of a more modern thing. There are a handful of organizations or consultants, if you want to call them, who are doing that kind of work.

And where we see ourselves is somewhere in between that not necessarily does the recipient of a sperm donor want to have to befriend the sperm donor today. Sure. Right. Maybe that's for them. Maybe that isn't necessarily for them. And I think it goes back to that thing I said early on of like a lot of right answers to all of these questions. And it's whatever feels good to that person, whatever makes them feel most comfortable and confident.

So we feel like we're going to kind of, we'll serve as that human connection. We've met and screened this donor, we're meeting the recipient, we're finding out what they really are looking for, and hopefully being able to make some level of human connection there without them having to build a relationship out of thin air tomorrow. That being said...

Devon: It has the backing of your company and your expertise, because I know there's websites and apps and things where people are just randomly meeting people to have a baby with. And I guess that makes sense for some people, but I could just see so many potential pitfalls that are eased by what you're doing.

Honestly, it kind of reminds me of what we do. Like you can find any night nurse on the street, but if you are working with a company like ours, you're able to have that support and that backing and that facilitation if there's any issues or your caregiver gets sick and you need coverage and just having that, those professionals involved, I think is so helpful.

Justine: I appreciate that compliment and definitely embrace that in how we try to approach this. Like we have psychologists and genetic counselors and even in like our probably four or five main staff members, if you added it up, it's like a hundred years of collective experience working specifically in reproductive medicine. We've all spent our entire careers doing this work and it's changing and it has changed and it will continue to change. And I tell people all the time that that's probably one of the best things about doing this work professionally is that what we told a patient two or three years ago isn't even really right anymore because we know more. And I think that leads to a unique group of people working in this field too, who are really comfortable in that gray area and like to say, well, today we know this. We know that six months from now we might give you a different answer. And we feel okay with that because that is the reality.

Devon: Yeah. And my mom, who was 71 years old when she was in college, so what, in the 70s, I mean before I was born. She talks all the time about how she did a paper for a class on new developments. It had to be on like the ethics of a new development in science. And she wrote about artificial insemination, like literally just the act of turkey-based or whatever insemination.

Justine: Right, placing the sperm into the uterus.

Devon: Placing the sperm into the uterus, whether it's your partner's or somebody else's or whatever and like, what are the implications of that? And she's like, I had no idea when I was writing that, like, what would be possible? Like what people would be doing? Like it's absolutely mind-blowing what they're capable of.

Justine: I mean, in the grand scheme of things, fertility treatment, IVF is all really quite new. Do you know what year the first IVF baby was born? You might know this. I ask this of every person I interview.

Devon: I do. It was like the late 70s or 80s.

Justine: 1978, Louise Brown, yep, 1978. That I knew. Was the first ever baby born from IVF. And that was in the UK. And then the first one in the US was shortly thereafter.

Right, so it was all kind of happening around the same time. But when we think of it, this is the age of the people who are doing IVF now, right? So it's one generation, really, you know, that we've been doing this, and that we've been able to do it. And there's been tremendous development in this technology. Like it was barbaric in comparison to what it is today.

And that's not saying that today it isn't daily injections, multiple injections, lots of transvascular ultrasounds, all sorts of other stuff.

Devon: Even for myself, I first heard about egg freezing, I guess, like maybe 15 years ago, 10 or 12 years ago. And it was pretty new. And at the time, they weren't really getting good results from frozen eggs. When I was young, I didn't have any money. I was like, I'm not going to spend all my money to freeze eggs that are going to be useless down the road.

And then all of a sudden there was this explosion and suddenly it was like, frozen eggs work. So then I, you know, got on it and froze my eggs.

Justine: This is like one of the most pivotal things that happened in my career too. So in like 2011, 2012, I got the opportunity at Weill Cornell's IVF program to build, kind of formalize the fertility preservation program. So we had always seen, you know, a young woman with cancer who needed to freeze her eggs quickly before her treatment started, but we didn't have a formal program. We hadn't been doing formal outreach really prior to that in a specific way. But it was starting to become a thing.

Egg freezing was under a research protocol. The patient had to sign a research consent. There was really not a ton of data on baby outcomes from previously frozen eggs.

Devon: So just to clarify, prior to this people were doing embryo creation, meaning that they would take the egg, they would take the sperm, make the embryo, and freeze that, but they weren't really doing just frozen.

Justine: And this is because of a technical limitation, if you will, of the egg. So the egg itself is a very large cell that contains, in comparison to other cells, still tiny, still microscopic, but a very large cell that contains a lot of cytoplasm, a lot of water essentially. And in the old freezing technology, it was called slow freezing, you would slowly drop the temperature of the embryo, the egg, the sperm sample, whatever it was. And then what they found with eggs was that there was ice crystallization happening in that slow freezing. When you thawed it, then the kind of organelles, the pieces of the cell had been damaged by that ice crystallization.

Devon: So they were basically getting freezer burned. I know. Right? For lack of a more technical description of it.

Justine: So around 2012, 2013, there was sort of an industry-wide switch to freezing embryos and eggs via vitrification, which is essentially like a flash freezing process. And that damage is significantly reduced in this process. So instead of what they probably told you in 2010, like, oh, maybe 50% of your eggs will survive or something like that, now we're able to tell patients about 90% of eggs survive the freezing and thawing, which is a tremendous increase.

Now, embryos still survive at a slightly higher rate, probably something like 95 to 97% of embryos survive the freezing and thawing. But there are lots and lots of reasons to freeze eggs without fertilizing them.

If you don't know what the sperm source should be, freeze eggs. It's worth that tiny difference in math.

Devon: When I did the consult call, I did egg freezing two separate times a couple of years apart. And when I did the first consult call the doctor was like, do you have a partner? And I was like, yes I do. I was seeing someone at the time and he was like, do you want to create embryos? And I was like, no I do not. No thank you.

Justine: And I think you know if we flash back probably 20 years there probably were people freezing embryos with partners who maybe they wouldn't have necessarily made that decision if the technology was different. But the technology truly wasn't different. It wasn't that they weren't being offered what was available. We just didn't know enough as an industry, as a society to do it better. And those of us who've worked in the field, of course, have all probably gotten a call like, can you take the sperm out of the egg?

And you never want to get that call. So I'm always very supportive of people freezing eggs and kind of leaving their options open. You can always use this current partner down the line if he's still your partner, right? But you can't take the sperm out of the egg. It's not a thing.

2012-ish, I got to formalize this fertility preservation program, and I got to really work on getting that word out. And it happened to kind of coincide with this great improvement in the technology. So then we really saw this huge kind of spike in interest of not just people who had a medical indication of upcoming cancer treatment or sickle cell disease treatment or gender affirming care or whatever their fertility preservation indication was. We also saw people doing it who were 33 and not in the relationship they thought they'd be in and not really ready to have a baby on their own and thinking, I should freeze my eggs so that my future self can use them. So you're sort of like being your own egg donor, right, when you do it that way.

Devon: And just to pause to clarify for people who aren't sure what you're talking about, fertility preservation basically means freezing eggs or sperm when you are going to go through something that's going to possibly affect that or...

Justine: Exactly, Yeah. So that's sort of how it's thought of. I would say, like, if I'm being probably as pure to the definition as possible, any freezing of eggs, sperm, embryos for future use is fertility preservation. And within fertility preservation, there are direct medical indications. Like I'm about to have gender affirming care.

I'm about to have chemotherapy. I should do this right before that so that I have this opportunity. Or there's more kind of planned reasons like I'm about to turn 35 and I think I should freeze my eggs or I'm about to turn 40 and I think I should freeze my sperm. I tell all my girlfriends to do it.

Justine: Really, people freeze sperm for age purposes.

Devon: Kind of future family building of their own. Yeah. Which that's definitely super new.

Devojn: Because you think, you know, the party line is that like sperm lasts forever, but I've been hearing more and more that it that age does affect that. Age definitely affects it. Robert De Niro and Al Pacino aside.

Justine: It doesn't mean people can't father a pregnancy at these very advanced paternal ages. Of course, we hear those stories. It does happen. If we did a semen analysis on the same guy when he's 30 and when he's 50, the semen parameters are very likely to have declined over that period of time.

Now do we see quite as quick of a drop off as you know, women see between 35 and 45? Probably not as quick. Is it quite as early as 35? Probably not, right? It's probably on a little bit of a delay. And for most people, there are millions and millions of sperm that we're starting with.

So it's also just the mechanism is entirely different, right? Women are born with all the eggs that they will ever be born with. And I'm using women and men, but you know, we're saying. I've had clients, people born with female organs, people

born with male organs, but ovaries have all of the eggs that you will ever have before you're born. And we actually start losing some eggs. This is like one of my other trivia questions. The most eggs we will ever have in the ovary are when we're a 20-week fetus ourselves. So we start losing eggs before we're even born.

Devon: Yeah, yeah, yeah. It's closer to 40. And not like- I know for a while the sort of news that you heard was like, at 35, it's all over, you're done. You're done. Your uterus is full of cobwebs, you might as well forget it.

Justine: I think that's not accurate, but also if we take all people across the whole population, do we see declines in fertility after 35? And do we see increases in abnormalities of the eggs after that time? Yes, right? If we take the whole population, does that speak to any one individual person's ability to get pregnant? No, not at all.

And that's where the fertility workup, the reproductive endocrinologist kind of comes in and can make these assessments. And none of us are going to completely bypass the impacts of age, right? Whether we like it or not.

Devon: But my mother was in full menopause at 35, 36.

Justine: Right. Some people, that's the case, right?

Justine: And that rate of decline isn't lovely, lovely, lovely, right? But that rate of decline sort of increases around 35. So we lose them more quickly. And at the same time, there is an increase in the aneuploidy or the abnormality of the eggs. So we sort of have two things working against us in the late 30s, early 40s, and that's what everybody talks about like a fertility cliff at 35, right?

Devon: I had two friends have babies at 43 and naturally 45, 46. And one was single and didn't think she was gonna have kids and had a run-in with an old boyfriend and the next thing you know, she's like, guess what? I'm having a baby and this is great and I'm gonna be a single mom and it's gonna be awesome and it was.

Justine: There are a lot of paths to parenthood, right? And some of them involve doctors and genetic counselors and psychologists and all kinds of other stuff and other people. And some of them involve going out for a party. So it just depends.

Devon: You never know.

Justine: You never know.

Devon: Let me ask you, what made you decide on a sperm bank as your path to a business? Where did you see the gap in the market that you felt like?

Justine: Sure. Thank you for asking that. I think it's a great question. I'm so curious about it. You know, so much of this field, rightly so, for the last, let's call it 50 years, right? Because there was a lot of work being done before that first IVF baby was ever born, it was focused on how do we get eggs? How do we get embryos? How do we do ovarian stimulation? How do we kind of do the female side of this? And that makes sense, right?

That is more complex than freezing sperm from a technical standpoint, for sure. But what we're seeing now is that technology works really well, right? We're talking about 90, 95% successes of certain things. We're talking about taking all comers to IVF and it's something like 35% chance of success if you take every single person. So things work in this process.

And how do we then kind of fine tune the experience? And There have been some papers that have come out over the last several years that the number one reason why people discontinue fertility treatment before their family is complete or what they imagined their family would be complete at is that the experience isn't palatable. It isn't the money, it isn't the physical piece of it. Those are the things that maybe we would automatically assume, but it's that the experience isn't good.

And to me, somebody working in this field, that's like, it's very disappointing because that should be the part that is easy, right? We're humans, we're working with people, we want people to feel comfortable and confident and good about what they're doing and they have to be so vulnerable with us. This is a

part of life that most people don't want to talk to anyone about, let alone a dozen people who work at their fertility center.

So I've been doing this work and so often we would hear from patients or we would say to patients, oh, go free sperm or something equivalent of that. And that was about as much information as they got. And it just didn't feel...

Devon: So they would do that at a separate facility, like a sperm...

Devon: Often they do it at a separate facility, depending on the specific plan. Or the fertility preservation patient, right? A young man with a cancer diagnosis is told, "Oh, go free sperm." And he's kind of sent on his own to figure that out and what that means. And what does he do with the frozen sperm?

Right? Like he has no idea. He's never contemplated this.

Sometimes he's 19 years old, right? That's just not, obviously that's not how it works. So I kind of saw that that could be done at the same sort of high level that professionals are doing IVF and egg freezing and that these things could be done in such a more thoughtful way. And so we see primarily a few different groups of patients. We see fertility preservation patients, sometimes medically indicated, sometimes because of planning for their own future family building.

We see a lot of known sperm donors, so friend and family sperm donors, or these facilitated known donors who need a whole set of heavily regulated testing and screening and sperm freezing, storage of those samples, etc. A lot of different parts to that, as well as kind of in a similar fashion, anybody who's going to provide sperm that will make embryos that will ultimately go to a surrogate also needs all of that specialized testing and screening. The whole concept of that is to reduce the risk of transmitting an infectious disease from the sperm provider to the surrogate. So it's all about protecting the surrogate. But that doesn't really fall in the purview of a reproductive endocrinologist.

Most of them did OBGYN residencies, became fertility specialists. They didn't set out to screen sperm donors, right? That wasn't really what they were doing. The facilities aren't really set up for it. It's not what their andrology lab was made for.

But these guys also don't really need a urologist.

Devon: Yeah, I've heard some stories of the room you go into with the God knows what kind of reading materials or whatever.

Justine: I promise it doesn't have to be gross.

Devon: The bigger issue that people have complained about is sort of the awkwardness, which, listen, I have done egg freezing, I have gotten transvaginal ultrasounds, I've gotten needles increases. Don't tell me that you feel awkward going into a room and pleasuring yourself. But I understand how it's not the most ideal situation.

Justine: We tried. And so we built this facility when I had this idea, right? So it's brand new and we got to kind of use what we, the industry, have learned over many years and hear what people haven't loved about that, right? So the way we have it set up, you don't have to bring the sample out of the door with you. There's a little pass through that you put it in there.

You turn it like an old school bank kind of thing. So you don't have to walk around with your sperm sample and it has a sound machine, it has a little lamp, and you have the ability to cast your own phone to the TV, we have no materials to scroll through or choose from.

Devon: Choose your own adventure, right?

Justine: Do whatever you like. And we actually have Eames chairs in the room. So it's, you know, it's really like, in my opinion, thoughtfully done. And I think it makes it easier for people. And it isn't the kind of thing that anybody's like, "Oh, yeah, my idea of a good time is to like to give sperm in public," right?

Like that, I understand that that's not on anybody's list. But can we make this where the experience feels appropriately professional, but not so clinical that it's horrible? And can we make it feel like they're being taken care of and that they trust the people they're meeting and who are going to monitor the alarms and manage the tanks and take care of the frozen vials of sperm, right? There's a lot of trust that has to be given by patients in this field.

Devon: Of course you do, but you have the actual sperm freezing on-site, the bank. We do.

Justine: Yeah. That's amazing. So some places do on-site storage, some places contract with kind of large cryo storage companies to do long-term storage that way, we've made a conscious decision that these patients are choosing us and meeting us and trusting us, and that we should be the ones then that they trust to take care of the frozen specimens. So that's our approach to it. But you can make an argument for any of the approaches.

There's no specific negative to any other one. I just think that's more aligned with our kind of overall approach and the personalization of what we're trying to do.

Devon: I love that. Yeah, it's very, very like a concierge, very like a boutique. And if people come to you looking for a donor and you have that matching process as well, I mean, I think that's that's great. That sounds based on my experience with people going through this process, it sounds like something that's really needed.

Justine: I think it fills one of the little gaps in between, right? In between having to meet your donor or scroll through a website, right? And it's not to negate the positives of any of those things. A lot of babies are born through those other mechanisms and people feel really comfortable with them and good with them. But are they for everyone?

Maybe not, right? And we're going to try a different approach and see if that feels right for some other people.

Devon: Yeah. So then you, I guess, are connected or work with the fertility clinics, so to speak, the reproductive endocrinologists that are then doing the next steps, the fertilization, the transfers, all that kind of stuff, and the egg part of the process.

Justine: We do, yes. So, you know, we can hold frozen samples, frozen sperm samples here, but ultimately, the patient will work with a full-service fertility center and these vials will get shipped to that center. Typically one vial is thawed

per fertilization event, like per egg retrieval or per cycle or attempt. So sometimes they'll get multiple vials and they have kind of a lot of flexibility for the future and they're able to figure out, you know, hopefully they'll be able to build their whole family from whatever they have.

Devon: A friend of mine who used a donor is connected not with the donor but with some other recipients, I guess, through the bank she used a few years ago, they gave you the option to connect with other recipients. She actually has met up with half-siblings of her son and she was able to get a little extra sperm from somebody who had some left over.

Justine: Oh, yeah. Some trading around some vials.

Devon: A little swap in, a little sending here and there. She's like, I'm done with it. I don't need it anymore. She's like, I'm not sure if I'm going to, but I don't love how much I have left, so why not get a backup?

Justine: Yeah, I think trying to get the same egg donor back for a full genetic sibling or get an additional vial of donor sperm, if that's what the goal is, is nice for people. Does it mean that people don't use two different egg donors or two different sperm donors. No, of course. And these are siblings and it really doesn't matter. But if it's an option, a lot of people like it.

Devon: Sure.So, God, there's just so much stuff. So interesting. I could go on forever. I mean, same. And I was like such a weirdo when I was young because I was so into babies. Like I always have been. That's how I got into this job, like taking care of babies and doing all that. I just wanted to know everything about them.

But then I also – this was like the, you know, mid-90s when I was in my early teens. It was when people were first doing fertility drugs and having quintuplets and sextuplets. The Octomom stories. That was when it went off the deep end. They would have a special 2020 about these six babies. And I'd be like, oh my god, I would eat it up. I just loved it. I just read every story about all the new technology and the things that were happening.

There was that woman who was a surrogate for her daughter. I think that was one of the early gestational carriers.

Justine: I feel like I remember that.

Devon: Yeah. I guess she was pretty young when she had her daughters. She was only 50. She's like, I'll be your surrogate. And then had twins for her. I read every art. I was thrilled. The Dions, remember the Dions from like the 30s that were like spontaneous quintuplets? I was obsessed with them.

Justine: I also find this fascinating. These stories are very sensational and certainly appealing to read about. And I love that you liked it because of the fascination with the babies and the fact that the technology existed. So much of it, unfortunately, was malpractice. So that's how we got to that, right? For sure.

And there's a part of me that's disappointed in the media, let's say, that these are the stories that get so much attention. And even now, right, that there are specials on some of the major news networks or on some of these major streaming platforms that are the dark side of this field and kind of imply that there is no oversight and that there's no regulation, there's no control over what's happening. And when, you know, doing

Devon: Well, I know things have changed a lot with the, even the multiples, like people are not transferred. They used to have like a 10% chance of success, so you'd throw in five or six embryos and hope for the best. Right.

And then once in a blue moon, you'd end up with four or five babies and you'd be like, crap. Or just fertility drugs that make you pump out all these eggs.

Justine: Maybe do an insemination when there was kind of like hyperstimulation, right? When multiple eggs might be ovulated. The other thing about transferring multiple embryos way back when was that the freezing technology wasn't great. So if you didn't transfer it, you might lose that embryo anyway, you know, and now almost everybody is transferring just one embryo.

There are some cases, people with many failed transfers, people with specific stories and cases that maybe more than one embryo is transferred, but by and

large has really moved to one embryo being transferred. And those other embryos now can be frozen like we were talking about earlier. So they aren't lost and they are potentially available for another attempt or a future baby, another baby.

Devon: Yeah. That is also a huge way things have changed as just the, I mean, even Phoebe on Friends having the triplets. And I mean, there were a lot of issues with that whole situation, but...

Justine: Way ahead of its time, because she was the gestational surrogate for her brother and his partner, if I remember correctly. And they probably liked the humor of not real incest, but kind of implying incest there.

Devon: Well, Lisa Kudrow was pregnant in real life, so they had to figure out a way to do something.

Justine: But that's actually not such a far-fetched idea that someone would be able to have the embryo transfer of their family member. And it's such a gift that they give them, right? It sounds so cliche, but-

Justine: Yep, it happens. Or sometimes people will transfer to a gestational surrogate and to themselves kind of at the same time, not knowing what will happen. And they end up with babies that are kind of twiddlings.

Devon: Yeah, I like that. Chrissy Teigen did that. You know, when you're not in this world that we're in, you hear these stories and you're like, whoa, that's crazy. But I could tell you-

Justine: It's not crazy.

Devon: Probably five anecdotes off the top of my head of people who have kids that are like three months apart.

Justine: Oh, I, yeah, absolutely.

Devon: they got pregnant after the surrogacy or whatever. And actually, that family reminds me of something else we wanted to mention, which is that they already had a child. They had a son, you know, normal, and they just could not

get pregnant a second time. They were really, well, they could, but for a long time they couldn't. And yeah, and that's more common than you think, right?

Justine: Totally. Like just because someone has had one successful pregnancy does not mean that the next pregnancy will be just as easy. And I think people sometimes really struggle with the idea that secondary infertility is real. It is just as real and just as common as primary infertility. And secondary infertility just means the inability to conceive or carry a pregnancy to term after having done so.

Where primary infertility would be like that you've never conceived or never carried a pregnancy to term. So it's quite common and I know you know some of your listeners may experience that And the rules of thumb are kind of changing over time. But the rule of thumb sort of is like if somebody is under 35 years old, and they've not been able to conceive with effort to conceive for a year, it's worth pursuing, you know, fertility workup. If they're over 35, it's more like six months that the recommendation is of trying and then pursuing a fertility workup.

But I always kind of think, like, if it's something that's on your mind, you're super worried about your ability to conceive. Doing the workup, being told everything looks OK, and then spending your year trying to conceive, there's no real negative to that. It's like a couple of appointments, right? And if that's going to kind of give you peace of mind, do a semen analysis. Make sure there is sperm. Do ovarian reserve testing.

Make sure it's kind of normal for your age, maybe a uterine evaluation that there isn't a fibroid or some sort of really obvious thing that might impair future fertility.

Justine: Yeah, you could spend a year trying and have some pretty obvious issues. And then it turns out that your partner has no sperm. That could totally happen, right? And that would be so disappointing if for like a $300 test, you could have known that and not spent that year of the highs and lows of hoping you're pregnant and not being and the disappointment is a really important part of this.

Devon: I remember friends of mine, their daughter just turned, oh gosh, nine maybe. She's so cute. But they got married kind of late. They were in their early

40s. Maybe she was 40, he was 40-something, and then they wanted to get pregnant, so it wasn't working right away.

So they went in and they did the testing and stuff. And I guess because of their insurance, like, you know, of course insurance is crazy and chaotic and a very hot topic right now and I hate everything about it, but they were basically like, cross your fingers that we have like round head sperm because if we do, they'll let us skip straight to IVF and like not mess around with like all the other things in the meantime that we can just like cut the BS and go straight to what's gonna work because you don't want to spend two years like screwing around and then literally figure something out.

Justine: The insurance definitely plays a role in it, right? Some insurance plans, even if fertility treatments indicated, sometimes say, oh you must do inseminations for three months, six months, whatever their requirement is before your benefits will trigger for IVF. Unless like you're saying, there's some specific reason why an insemination couldn't possibly work, then maybe you can bypass that. And then there's also, I think about this a lot. I talk about it a lot with our patients . Some people want to try inseminations first because they're less invasive and per treatment, they're a little less expensive. The cost-effectiveness literature, though, doesn't really support that.

The efficiency of IVF, even though one IVF attempt is more expensive than one IUI attempt, the cost-effectiveness leans toward IVF being the preferred treatment plan for most people.

Devon: And insemination is still valuable for, say, lesbian couples or single moms or somebody who, right?

Justine: I think like if someone's never been exposed, oh totally, it's always an option.

Justine: Yeah, unless somebody has blockages in the fallopian tubes, insemination is not a good idea, right? If the partner has a really low sperm count, insemination is not a good idea. There are a handful of reasons why that wouldn't be a great idea. If you've never been exposed to sperm, single mom by choice, same sex female couple, why not try it? That doesn't mean the cost

effectiveness literature still doesn't say maybe do IVF, but could you get pregnant from an IUI?

Of course, any exposure to sperm you could get pregnant from, right? But there is sort of this rule of thumb on the male factor side of it, which we end up talking to people about all the time, that to do an IUI, most physicians want to see at least 10 million motile sperm after all the processing, after the freezing and thawing. So you actually have to start with quite a high sperm count to get to that based on the volume of the sample that's in the vial, the percent that survived the freezing and thawing, the percentage that are actually moving. The threshold to use a particular sperm sample for IUI isn't low. It's pretty high.

And with IVF, you'll, in theory, only need one sperm per egg. So you can work with a much less high quality per the numbers sample and still potentially end up with success. So It's amazing what's possible.

Devon: And there's been, and obviously this would be something that you would be knowledgeable about doing what you do, what's called male factor infertility, right? Where the sperm producing member of the team has the issues, I think that that's been somewhat overlooked and ignored previously in the past and now they're doing a little bit more sort of research into that. And like we were talking about the age thing, I think the assumption was that, like, oh, well, you've got sperm, it's fine, whatever. It's obviously her problem, woman.

Justine: There's been evolution in this too, right? That you used to hear people say, oh, infertility is 30% female factor and 30% male factor and 30% unknown. But I mean, okay, maybe, but like, is that actually useful information to anyone? I'm not really sure that's so useful. It's probably, you know, 50-50, but really a combination for everybody is in most cases, right?

There are a lot of things that affect male infertility or sperm production and some of them are environmental and modifiable, right? If somebody uses a lot of cannabis products, if they smoke cigarettes, those things can really directly affect the semen analysis. But the positive is spermatogenesis, or your body making sperm, is only like a three-month process. So if you can cut back on

those things or eliminate them entirely, you might actually see real meaningful improvement in a relatively short amount of time.

There are medications, like some hair loss medications can really affect this human analysis. People don't necessarily know that. The person who's prescribing the hair loss medication isn't necessarily directly addressing that. Like, oh, do you have future family building plans? Isn't necessarily part of that counseling.

Then there are some more extreme things like people taking testosterone supplementation almost always will completely eliminate sperm production. But that isn't necessarily part of the counseling either. Now, those things in many cases are reversible, not 100% of the time does it kind of reverse on its own if you stop it. So there's a lot to think about with this.

And I think that's where we've seen a lot of improvement of the conversation and the reducing of the taboos of bringing it up as a subject, right? Where, you know, I don't know if it's just that being socialized as women, you know, people are thinking about their fertility more frequently, and the patients are kind of motivating a lot of those questions, maybe that's shifting a little bit.

And maybe, you know, more and more young men are thinking like, I do want to have a baby in the future, like, is this thing I'm doing now likely to be okay, or is it maybe a problem? And, you know, I think one of the things that we sort of do here is we want to educate those providers and we want to be a resource to them. So if you are a provider who's regularly prescribing hair loss medications, Call us, talk to us about it. Let's see what information we can provide your team and your patients and make sure everybody feels like they've gotten everything they need to know when they're making these decisions, because it's all connected.

Devon: Yeah, I think that's so important and there's so many things that affect it that you might not even think about. And I know when you're young, it's like, oh, that's years away. I don't have to think about that or I don't have to worry about that. I mean, I wish people thought about what they're gonna do with a baby like 10 years before they actually have one. Little girls dream about their wedding

and it's such a cliche that you're cutting out pictures of wedding dresses in magazines. I want you to think about sleep training.

Justine: You mean nobody's thinking about how they're going to sleep train their baby doll?

Devon: You know, they should. I think what it teaches them is that you're gonna give birth to a baby doll and then you're pretty shocked when it actually gives birth to an alien.

So yeah, so I think it's important that people think about this and especially, I mean, this could be a whole other topic that we don't have to go into, but as people, younger kids are doing gender affirming care and stuff like that, thinking about how it affects things and what they want to do and having to make those choices a lot earlier.

Justine: I think that's such a big thing. And we see patients for sperm freezing before gender affirming care regularly. And some of these patients are 20 years old. Some of them are 50 years old and about to pursue gender affirming care for the first time. So it's a wide range.

And I think one of the things, and maybe the take home from even that little bit of an anecdote is like, as the endocrinologist who's managing their gender affirming care, you can't assume who might want future fertility or who automatically doesn't want future fertility. And freezing sperm can be very dysphoric for patients who are pursuing gender affirming care. It can be a really emotionally charged thing.

But what we understand is it's much less problematic to freeze the sperm ahead of time than to have to consider coming off of their treatment, see if spermatogenesis returns, see if they can free sperm later on. And to do one or two appointments, it's a few hundred dollars in the grand scheme of everything they're gonna do, pretty approachable, not without some, a lot of layers for a lot of people, right, and understand what it means and understand, you know, if the analysis isn't great, what can you do with that sample in the future?

That's something we talk about with a lot of people, sometimes not necessarily gender-affirming care cases, but let's say somebody has testicular cancer or they have leukemia. Often by the time they're diagnosed, the sample doesn't look great because it's already been impacted. But that doesn't mean that that sperm is not usable for IVF in the future. It may not be great for an IUI, but it might be perfectly suitable for IVF.

And that's part of what we try to do here is like really interpret and help these patients versus say, okay, you have a vial of frozen sperm. What does that mean? It means something different depending on the parameters and the goals and the likelihood of regaining spermatogenesis in the future. And so we try to have those conversations with people and make them feel as empowered as they possibly can.

Devon: That's so important. And teaching this to guys, right? Like my partner, as our friends are having babies, our friend who's a single mom by choice, our friends who are the gay couple using surrogate, like he's a smart guy. He has a PhD in math and he knows absolutely nothing about any of this because he's never been exposed to it. So then, you know, when we talk about the possibility of having a baby in the future and I'm older and I have my frozen eggs and it's likely we would have to do some – he's absolutely clueless.

So I'm like, we gotta get you somebody to talk to where they'll help you understand this. I'm gonna connect him with you. I'm a volunteer for that. I'm sending him your way, seriously. You do the testing and stuff, right? We'll get him tested for sure. We'll get him everything, I'm not messing around.

Justine: We talk, we test, whatever's needed. No, sometimes I like joking with these guys. I'm like, okay, do you know what to expect from a semen analysis report? They have no idea.

Sometimes people think, oh, there should be a few hundred sperm. More likely there should be a few hundred million sperm. Right. And you know, that's just something, it's kind of a number that none of us can fully comprehend what that even means. But really, there are kind of no expectations, right?

Or, you know, people just really don't know what to think. And then one of the ones that shocks everyone is, we look at sperm morphology. So think of it like a textbook or a cartoon, right? The head, the neck, the tail, the shapes of the sperm. And the normal range for that is that we want 4% of the sperm or more to be normally shaped.

It's a single digit. Like the best we ever see is like 6%. So 4% or 5% of sperm are normally shaped. So you might have 100 million sperm, but only 4% of them are likely to be normally shaped. And sometimes that's only 1 or 2% of them are normally shaped.

That always shocks people. They think that 96% of them are going to be normally shaped, and that's not the case.

Devon: If I was very quickly making 10 million of something, they would not anywhere near be normally shaped.

Justine: Exactly, exactly.

Justine: Exactly, exactly. So it does make sense.

Devon: That's a great analogy.

Justine: But it's true. And then we're over here every month lining the uterus and picking out the egg and putting all this care into the process. So it's just a whole different ballgame. That's crazy. I never knew that.

Devon: Yeah. So that's something that is always quite surprising. I think every single semen analysis report I call and explain, I'm having to really explain the morphology. No one's expecting that unless they've done this before. Yeah, because I'm sure you see that and you're like, ah, there's no way.

Justine: Oh, yeah. Yeah. They would really be quite shocked and think it's terrible and 4% is great. We're like, oh, yeah, this is good.

Devon: Okay. So that leads me to two questions I want to ask you. One is a nice one and one is kind of a fun one.

Justine: Is there such a thing?

Devon: Mean to people who might be listening. Oh my goodness. The nice one is, what is the one thing you wish people knew that you feel like people should know about your field, about this area?

Devon: I mean, based on how little people know about birth, breastfeeding, all of that before they have a baby, I'm sure they don't know very much about the other stuff either. It's just not out there. The information is just there unless you're looking.

Justine: I mean, I probably have like 25 things that I could answer for that list. But I touched on this one a little bit earlier. I think there's a misperception out in the world that this field is the Wild West, that there aren't regulations, that there aren't rules, there aren't standards of care. And that, in my opinion, couldn't be farther from the truth. The FDA, the Department of Health, and many professional oversight organizations are inspecting and creating regulations and requirements and rules for how people are protected in this field.

Now, does that mean we agree clinically with every single one of those rules? No, there are plenty of them that philosophically we don't think make a ton of sense, but they are the rules. They were intended to be there for a reason. And with appropriate counseling, education, understanding, any patient can navigate through this process. So it's really about finding the providers that can help you get through the process in a way that feels aligned with your own family building goals. So I think that's one thing.

And then I think we just talked about some of the other ones, right, that people don't know that women are born with all of the eggs they're ever going to have, or that what a semen analysis report might look like, right? Like there really are kind of is not a ton of baseline understanding. And I guess in seventh grade biology, we don't really get that part of it, right? That isn't what we're taught in school. And maybe eventually it will be.

Justine: And then I guess the last thing I'll say is that fertility treatments are not a perfect solution to everything. It doesn't mean just because you're gonna do IVF and it's expensive and time consuming, it doesn't necessarily mean it's gonna

work. And that's one of the hardest parts of this, of doing this work or of being a patient is that there are no guarantees in this. And we give probably more bad news than good news as a whole.

But if you're creative, if you have the right team with you, if you're persistent, you can be a parent. It may involve some, you know, generous folks who wanna be egg donors or sperm donors or surrogates and then a whole host of lawyers and other people too when you get involved with that. But it may involve more steps and more things. But if it takes 50 steps and you work with somebody like me or some of my colleagues in this field who are happy to go down those 50 steps with you, that's what you do.

Devon: To that point and to what you were saying earlier, if you're in the process and you're not loving the experience, you can change clinics. You can find a different provider. You can have an experience that is better than the one you're having if the issues are that.

I know when I was freezing my eggs, I worked with a lovely clinic, very small, they mostly focused on egg freezing and stuff like that. So when I would go for my monitoring, it was lovely. And then sometimes I would have to go for monitoring at a different clinic, and it was one of these huge ones that was like churning out a million people.

I'd be sitting in the waiting room with like 40 other people, like just there for them, you know, it's 7 a.m. I'm like, if this was my experience every time, I would hate this. Like, I saw the same nurses, the same, you know, caregiver. It was great.

Justine: For some people, that, like, human connection of, like, the same person who does my ultrasounds 80% of the time is what they're looking for, right? For some people, they get some kind of camaraderie out of the fact that there are 80 other people in the waiting room with them, and they're like, oh, I'm not in this alone. A lot of people are doing this.

Devon: I mean, for me, it was, I'm a tough stick for blood draws, so I was happy that they knew me and they knew that only certain people could do it.

Justine: They knew what to expect.

Devon: They knew what to expect and then they were not going to traumatize me.

Justine: Yeah, understood. But I guess there's a right place for everybody. And it is a little bit more of a consumer product than some other types of medicine. So you can change, right?

You have a choice in where to go. In New York, I'm New York-based. I think you're New York-based, too. There are like 30-plus IVF or fertility programs in the New York metro area, there's a place that will feel right for somebody here. And this is just like a random statistic, but about 20% of all the IVF cycles in the entire country are done every year within 30 miles of New York City.

So this is like the place to be if you need fertility treatment. And we see people travel from all over the world, all over the country to have fertility treatment here.

Devon: My cousin's surrogate was based in another state and they tried to transfer here and it didn't take and they suggested doing a transfer rather than having the surrogate travel. They FedExed the embryos. I didn't even know you could do that. And now they're 13 year old kids. I just saw them for Christmas."I was like, you were FedExed. It's crazy." Yeah.

Justine: There's a lot of courier companies in this space too who are moving tissue around.

Devon: I figured it would be some kind of super specialized whatever. She's like, no, FedEx does it. Like, okay. Justine: Often coordinated via FedEx, yes.

Devon: Okay, so now here's the other question.

Justine: All right, the mean question?

Devon: The mean question. What is something that you are like, surprised people don't know? What's like a dumb question you've gotten maybe more than once, maybe just once? I'll tell you what mine is.

Justine: Oh, yeah, tell me.

Devon: When I'm explaining my job to people, we help people who have a new baby, we support them with different things, we support them with breastfeeding more than once. And it's almost always a man, I think it's always been a man, says, "oh, like you breastfeed the baby for them?" And I'm like, no, that's a different thing, and we don't really do that anymore. And also, that's not a thing. And also, like we're on a date. Why do you think I'm lactating right now?

Like, Why do you not understand how any of this works?

Justine: I'm sure that that existed much later than this, but I immediately think of it like a 1850s period movie when I think of that.

Devon: You know, there is informal milk sharing and people nursing each other's babies, and I think it's great. I sleep train two babies for sisters and they would watch each other's babies. There's nothing wrong with breastfeeding someone else's baby. Of course. But it's not generally what you would hire someone for as their job, especially someone who does not have their own baby.

Justine: I mean, my silly answer is we do get asked sometimes, like, "how will the sperm get out of me?" Occasionally that gets asked. You know, obviously we can explain it to people and masturbation's not necessarily part of everybody's life

Devon: I'm sure they're more happy to learn that answer than that you have to go in with a giant needle or something.

Devon: It's incredible. And I mean, like I said, I've been, obviously from a lay person's perspective, but I've been watching the field change over the last 10, 20 years. And it's just been incredible to see all the improvements, but you're right, there's no guarantees. Unlike sleep training, which works because it's expensive. And we can pre-screen people.

Like if I think there's something going on with your baby that sleep training is not going to work for them, or I think that you're not on board, I'm not gonna tell you that it's gonna work. So, but with fertility, you don't know. You don't know.

But with fertility treatment in general, I would say there's an assumption, and I don't know if this is like my own extrapolation or if this is what other people would think. I think that there's a subset of the people who pursue fertility treatment who think it's because it's so hard to do and it's so resource intensive and requires so much money and effort and time that it's gonna work. And I would love that to be the answer. I would love to say, yes, it's always going to work. And unfortunately, that isn't the answer.

Now, does it work? Yes, it works, right? Will my future babies likely come from fertility treatment? Yes, for sure, from those frozen eggs, right? But I think there is a subset of the group who's like, Oh, well it's so expensive. So it must work. And that isn't how that works, unfortunately.

And it is so expensive because it requires specialized equipment and specialized people and a tremendous amount of blood testing and highly trained physicians and nurses and embryologists and all kinds of people to actually make this happen. And those lab people, they are amazing at what they're able to do. And they're not who anybody thinks about when they're pursuing fertility treatment.

But these people are assessing each egg, each embryo, helping decide which one should be transferred, which one has the best likelihood of success, which one's going to give you your baby. And it is amazing that they can do that.

Justine: You don't know. And I think one of the things that I always felt so proud of at the place that I worked previously and something that I think we try to really fully have embraced in everything we do is that if something isn't going to work, like somebody who's 52 says they want to do IVF with their own eggs, they shouldn't do it. The risks outweigh the benefits in a case like that. And if there's a doctor who says, oh, but I'll give you a chance, there is no data to support a decision like that. And the risk of bleeding from an egg retrieval is not zero.

Right, It's something. It's not super dangerous where people shouldn't do it, but it's not zero. And the likelihood of success with IVF based on everything we know over the last 40 plus years is that it's not going to result in a baby. I hate to

see when people are told like, oh, just keep trying, keep trying, keep trying, and do the same thing over and over. That doesn't feel right to me.

Devon: I cannot imagine being 50. I can't imagine being pregnant now. I cannot imagine being 52 and pregnant.

Justine: That- People definitely can carry pregnancies, right? Like we see people have, you know, maybe their own embryos from years before or embryos from donor embryos or donor eggs. And we definitely see successful pregnancies, but are they going to conceive with their own 52-year-old eggs? Sure. I would love to see the day, but it's not today.

Devon: Well, it's like if I had a baby when I was 25, I would just, you know, be a mom. Now I'm like, nanny, please, I'm not chasing around a two-year-old. I have done that. It's exhausting. I don't have the energy or the stamina anymore. I will read books, do puzzles, and someone else can be the runaround parent because it's not going to be me.

Yeah, but oh, I think that's great and I think what you're doing is great and I mean, you know, obviously our jobs are different but so similar I think in that that personal touch, that care, that you need more than just go to a sperm bank and do what you need to do.

Justine: And I think like the vulnerability on the side of the client or the patient, right? That they are coming to you saying, I don't know what to do. Like I need help. Right? And that people are coming to us saying, I don't know how any of this works. Can you tell me? And also I don't want to talk about it with anyone because I don't want to say these words out loud, right?

And the fact that they're able to come to us and say that and that you're the person they trust with their baby and with themselves when they're at their most vulnerable. I think that there's definitely a parallel there.

Devon: Everyone struggles. People are sometimes so embarrassed coming to us. I just don't know what to do. I'm nervous about having a baby, and I don't know what to do, and everybody else seems to have it figured out. I'm like, they do not. They do not.

Justine: They absolutely do not.

Devon: You are not alone at all.

Justine: And that's true with us too, right? Not everybody has an easy time getting pregnant. It doesn't look exactly like what they imagined it would look like. There are hundreds of people in the waiting room every single day at fertility centers. And you're with these people. And many of us, you, me, and all of our colleagues have dedicated our whole careers to doing this work because we want to help these people. So plenty of parallels for sure.

Devon: And then I just thought of one thing I wanted to say earlier when we were talking about ethics around donor stuff, which I would love to have you back just to talk about because it's so fascinating.

Justine: I mean, that's like my actual favorite topic in the world.

Devon: I love it. But one thing that I think is funny is that that's actually not that new, even though donor conception and everything is so new. Because think about generations ago, who was having an affair? Whose dad is not their real dad? Who was secretly adopted?

Justine: Oh, for sure.

Devon: Our parents' generation, like how many people who couldn't have kids just like bought a baby and like, hey, look, we had a baby, surprise. And those kids are not with their genetic families. And now that we have all these DNA tests and everything, people are finding A friend of mine found out her dad was not her real dad. Like, what?

Justine: I mean, there have been some really high-profile people. I think Kerry Washington has a whole book or a whole piece about it that she always felt like there was something missing between her and her parents. And then as an adult found out that she was not genetically related to her father. And she was like, well, that just makes it make sense. I'm not mad. I just like it, it all adds up now.

But what makes me think that you brought that up is when I wrote my dissertation, it was on donor sperm preparation. I now seem super organized, like I was planning to open a sperm bank back then. I had no idea that that would be the path, but here we are.

Devon: Oh, when I look back at my babysitting empire that I had in middle school and high school, I'm like, why did I not see this coming?

Justine: Yeah, I didn't see it coming either.

Devon: I was babysitting for everybody in the neighborhood. Why did I not think this was going to be my career?

Justine: There's a ton of history in the beginning of my paper. And There's a whole era, 40s, 50s, where, "the most handsome medical student" was called over to provide sperm when someone couldn't conceive. And back then, they were often mixing it with the sample of the husband. There was plausible deniability and everybody just carried on and well, we got a baby, right? Yeah, you hear

Devon: Those stories like the doctor turned out to be the father of like 100 kids.

Justine: I mean, there's some super malicious versions of that story. And then there are some of these stories where societally that was like a well-known secret, right? And that was just what was happening. Those malicious stories, that's one of the sickest, most horrible things I've ever heard.

Devon: No, this seems, you know, maybe not totally innocent, but more like many, many years ago the doctor was doing research and was using his own samples because he couldn't procure that many different samples. And then it turned out that he was prolific. And yeah, and again, just to your point, things are much better regulated now and not the Wild West. I will say sperm donation, I think, can be, especially if you're doing it outside of proper channels. And I hope that they're able to…

Justine: I mean, we certainly encourage people to work with a sperm bank, work with a fertility center, get the right genetic testing, psych testing, infectious

disease testing. These things that are protective for yourself and for the donor. In legal contracts, they protect the donor as much as they protect the recipient. Try to make sure that it's as safe for everybody as possible and as sustainable as possible. This is a lifelong commitment that you're making.

So it's a big choice.

Devon: Yeah. Well, Justine, thank you so much. This was so great. Where can people find you?

Justine: So our website for the company is alineagefertility.com, and I'll spell it because I made up the most complicated word spell in the world. It's A-L-I-G-N-E-A-G-E fertility.com. We're also on Instagram @alignandlineage, which I thought was wonderful. Turns out it can't be spelled.

Devon: I thought Happy Family After was the cutest business name. And then people are like, oh, happily ever after your company. And I'm like, no, not exactly.

Justine: Yeah. So we get a lot of interpretations of how to say and spell it and we're just embracing all of them. But yes, that was the inspiration, alignment and lineage so that it feels like aligned with your own goals. So we're on Instagram, we have a website. We'd love for people to call us and email us and we do one-on-one consults.

The example I always give is like, single dad hasn't the faintest idea where to begin. Call us, we'll kind of lay the groundwork in the consultation. They don't have to do any clinical work with us necessarily, but we can just teach you for an hour. And you can feel like, oh, I know what question to ask or what things I'm going to need. And we love doing that kind of stuff.

We do group work. We'll work with professionals as well. If there's like an oncology group that wants to better counsel their patients on fertility preservation, we talk to them. So there are a lot of different ways that we can work with people.

Devon: I think that's important too because they probably don't teach you that in oncology school. It's such a different specialty. Even the OBGYNs don't necessarily know about sperm and that stuff.

Devon: Sometimes, you know, and I have said this publicly a few times, but I don't think it's a reasonable expectation that the oncologist or the endocrinologist or the hair loss specialist is gonna be the fertility expert. They're not, but they should know enough to say to people, "hey, this might affect your future fertility. We know some people you can call if you want to know more about that." I think that is their responsibility to say that. I don't think it's their responsibility to say, well, if your semen analysis is X, Y, and Z, this is what treatment options you have in the future.

That's not their specialty. Just like I don't know how to manage those types of medical care. So it takes a team, it takes a village, everything takes a village. You do all of this, it takes a village, then you need a village to raise the baby too.

Justine: Then you do this, then you need a village. Exactly. Exactly. And we'll put all those links and stuff in the notes as well.

Devon: Wonderful. Thank you. So we can find you.

Justine: Yes. Thank you so much for having me. I'm so glad to have been here.

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Thanks for listening to this week's episode of *Parenthood Prep*. If you want to learn more about the services Devon offers, as well as access her free monthly newborn care webinars, head on over to www.HappyFamilyAfter.com.